INFANCY, CHILDHOOD &
RELATIONSHIP ENRICHMENT INITIAL ASSESSMENT (May Be Used for Birth -5 yrs)
(See Reference Manual)

MH-645
Revised 10/1/15

Initial Contact Date: _____ Date Form Completed: _____

I. IDENTIFYING INFORMATION

Child

Name: _____ DOB: _____ Age: _____

Other Names Used: _____ Gender: ☐ Male ☐ Female

Ethnicity: _____ Preferred Language: _____

Referred by (Name & Number): _____

Agency of Primary Responsibility

Refer to "MH 525: Contact Information" form for detailed contact information.

☐ DMH ☐ DCFS
☐ Probation ☐ School District
☐ Others _____

Biological Parents

Mother's Name: _____
Marital Status: _____ DOB: _____
Address: _____
Phone: _____ Work: _____
Preferred Language: _____
Interviewed: ☐Yes ☐No Interpreter Used: ☐Yes ☐No
Language Used for Interview: _____

Father's Name: _____
Marital Status: _____ DOB: _____
Address: _____
Phone: _____ Work: _____
Preferred Language: _____
Interviewed: ☐Yes ☐No Interpreter Used: ☐Yes ☐No
Language Used for Interview: _____

Primary Caregiver (Complete only if Biological Parent is not the Primary Caregiver)

☐ Adoptive ☐ Guardian ☐ Foster ☐ Kinship/Relative ☐ Group Home ☐ Other

Name: _____ Relationship to Child: _____ DOB: _____

Address: _____

Marital Status: _____ Phone: _____ Work: _____

Preferred Language: _____ Language Used for Interview: _____ Interpreter Used: ☐ Yes ☐ No

II. REASON FOR REFERRAL/CHIEF CONCERN

Why Referred? Type of help family is hoping to receive.	
Current Primary Symptoms/Behaviors impairments in life functioning	
Describe Onset, Duration& Frequency	
Describe child & family strengths	

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

HISTORY OF PROBLEM
(Caregiver perception of cause, attempted solutions, possible triggers to onset, etc.)

ADDITIONAL PROBLEM AREAS
(Sleeping, eating, toileting, self-care, social/peer relations, tics, etc., frequency & onset)

III. PHYSICAL STATUS

SOURCE OF INFORMATION: □ PHYSICIAN CONSULTATION □ MEDICAL RECORDS □ PARENT/CAREGIVER REPORT DATE OF LAST PHYSICAL_____

ACUTE ILLNESS/MEDICAL PROBLEMS: (List) _____

CURRENT MEDICATIONS: _____

□ CHRONIC ILLNESS □ FAILURE TO THRIVE □ GROWTH DELAY □ NUTRITIONAL CONCERNS □ ASTHMA □ ALLERGIES

□ EAR INFECTIONS: # OF TIMES TREATED WITH ANTIBIOTICS PER YEAR: _____ □ IMMUNE-SUPPRESSED

□ DEAFNESS (Partial / Total) □ BLINDNESS (Partial / Total) □ LEAD LEVEL TESTED: (Date/Details) _____

IMMUNIZATIONS up to date: □ Yes □ No □ INJURIES/TRAUMA: (Type) _____

NEUROLOGICAL: □ SEIZURE DISORDER □ AUTISM □ CEREBRAL PALSY □ OTHER: _____

BRAIN TRAUMA: (Date/Details) _____

SURGERIES: (Date/Details) _____

OTHER CHRONIC HEALTH PROBLEMS: _____

VISIBLE ABNORMALITIES/MALFORMATIONS (Head, Hands, Spine, Extremities, Face, Genitalia, Skin): _____

DETAILS REGARDING ABOVE:

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

IV. DEVELOPMENTAL HISTORY (ADD PAGES IF NECESSARY)

PRENATAL/PERINATAL INFORMATION

PRENATAL CARE: □ NONE □ INTERMITTENT □ REGULAR □ OTHER: _____

PRENATAL COMPLICATIONS/CONCERNS: Illnesses, accidents, stresses during pregnancy. Maternal use of alcohol, drugs, cigarettes (specify?) _____

_____

_____

_____

POSTPARTUM PSYCHIATRIC PROBLEMS: □ NO □ YES (Onset & Duration) _____

_____

BIRTH HISTORY

TERM (mos.): _____ BIRTH WEIGHT (LB/oz): _____ BIRTH LENGTH (inches): _____ MOM's AGE: _____

LABOR DURATION: _____ CHILD DAYS in HOSPITAL: _____ PLACE OF DELIVERY: _____ DAD's AGE: _____

TYPE OF BIRTH: □ NATURAL □ INDUCED □ C-SECTION □ FORCEPS □ VACUUM TYPE ANESTHESIA USED: _____

BIRTH COMPLICATIONS: _____

MOTHER/CAREGIVER PERCEPTIONS OF PREGNANCY & BIRTH (Planned or surprise? Your/father's reaction? Support?)

Breast-fed/Bottle-fed combination? Duration and age weaned? Age of taking cereal, solids. Types? Feeding difficulties? Frequency & onset? Spitting up, sucking problems, refusal to eat, over-eating, fussy eater? Frequency of eating? Signals of hunger/satiation? Self-regulation?	**FEEDING**

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

	SLEEPING PATTERNS
Good sleeper? How did s/he sleep in past week? Last night? Is this typical? Length and frequency of naps, nighttime sleep? Difficulty falling asleep, waking? Frequency & onset	
	TEMPERAMENT
Describe your child's personality: over-active/highly reactive or under-reactive/slow to respond, easy-going, anxious? Is your baby colicky, fussy, cries a lot? How often & how long does your baby cry? Is it easy to read your baby's signals and moods? How responsive is your baby to you? Easy or difficult to soothe? What soothing strategies do you see?	

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

INFANCY, CHILDHOOD &
RELATIONSHIP ENRICHMENT INITIAL ASSESSMENT (Continued)
(**See Reference Manual)**

IV. DEVELOPMENTAL HISTORY (Continued)

Developmental Milestones (Describe if not within normal limits) **See Reference Manual.** Address domains: sensory, motor, socio-emotional, language, cognitive and adaptive / self help		**Environmental Stressors** **See Reference Manual.** Moves; schools; separation; losses of family/friends, changes in family composition, SES, lifestyle; exposure to family conflict/violence; major illnesses; abuse; placements, etc.
Infancy: 0-6 mos. Smiles back Rolls over Turns to sound Babbles Plays with objects		Infancy: 0-6 mos.
6-12 mos. Stranger anxiety Sits upright/walks Responds to name Object constancy Says 1-2 words		6-12 mos.
12-18 mos. Reciprocal play Eats with spoon Tolerates noises Jumps with 2 feet Says 4-6 words		12-18 mos.
18-24 mos. Words for feeling Balance on 1 foot Brushes teeth/hair 2-3 word sentence Pretend play		18-24 mos.
24-36 mos. Toilet trained? Throws ball Uses "I" 2-step request Uses "big/little"		24-36 mos.
36-60 mos. Uses scissors Climbs a ladder Uses sentences Draws a line Symbolic play		36-60 mos.

DEVELOPMENTAL ASSESSMENT TOOLS & RESULTS
(list questionnaires or formal testing)

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

V. CURRENT FAMILY SYSTEMS REVIEW	
Family Members Living in Child's Current Home	
(Identify relation & age)	
Who else lives in your home? Apt/house? Enough space? Always lived here? Family relations Get along with each other? Extended family? Friends? Social/ other supports? DCFS support? Family History: Medical Psychiatric Legal/Criminal Alcohol/Drug Family cultural identity? Immigration history? Religion? Spiritual practice? Family strengths?	
DCFS/Abuse/ Placement History & Plans	

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

V. RELEVANT PAST FAMILY SYSTEMS REVIEW (Complete only if client has had more than one Relevant Family System)	
Family Members Not Currently Living in Child's Home	
(Identify relation & age)	
Who else lived in your home? Apt/house? Enough space? Always lived there? Family relations Get along with each other? Extended family? Friends? Social/ other supports? DCFS support? Family History: Medical Psychiatric Legal/Criminal Alcohol/Drug Family cultural identity? Immigration history? Religion? Spiritual practice? Family strengths?	
Family Visitation & Involvement Plan Visitation schedule Engagement in child's assessment	

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

VI. CHILD CARE / EARLY INTERVENTION / PRESCHOOL SERVICES

CURRENT DAY CARE, CHILD CARE OR PRESCHOOL

□ DOES NOT ATTEND CHILD CARE □ ATTENDS LICENSED DAY CARE □ ATTENDS UNLICENSED CHILD CARE
□ CURRENTLY NOT ENROLLED IN PRESCHOOL □ REGULAR PROGRAM □ SPECIAL EDUCATION PROGRAM

CHILD CARE/PRESCHOOL NAME: _____
CONTACT PERSON: _____
ADDRESS: _____
PHONE: _____
DAYS/TIMES PER DAY CHILD ATTENDS: _____
PARENT PARTICIPATION: _____
NOTABLE INFO: _____
DATE OF LAST IFSP/IEP: _____
IFSP/IEP ELIGIBILITY: _____

ADDITIONAL CHILD CARE: _____
CONTACT PERSON: _____
ADDRESS: _____
PHONE: _____
DAYS/TIMES PER DAY CHILD ATTENDS: _____
PARENT PARTICIPATION: _____
NOTABLE INFO: _____

EARLY INTERVENTION or REGIONAL CENTER SERVICES

□ CURRENTLY NOT IN EARLY INTERVENTION PROGRAM
DATE ENROLLED: _____
NAME OF PROGRAM: _____
CONTACT PERSON: _____
ADDRESS: _____
PHONE: _____
DAYS/TIMES PER DAY CHILD ATTENDS: _____
SERVICES RECEIVING: _____
PARENT PARTICIPATION: _____
NOTABLE INFO: _____

□ HISTORY OF EARLY INTERVENTION PROGRAM
DATE ENROLLED: _____
NAME OF PROGRAM: _____
CONTACT PERSON: _____
ADDRESS: _____
PHONE: _____
DAYS/TIMES PER DAY CHILD ATTENDS: _____
SERVICES RECEIVING: _____
PARENT PARTICIPATION: _____
NOTABLE INFO: _____

HISTORY OF CHILD CARE / EARLY INTERVENTION / PRESCHOOL or SPECIAL SERVICES

(CONSIDER: licensed/unlicensed facility, #children in class, age range of children, nature of relationship with teachers/caregivers, peer relationships, parents' perception of support from teachers/caregivers, history of threatened or actual suspensions or expulsions from day care/pre-K, etc.)

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

VII. MENTAL STATUS / BEHAVIORAL OBSERVATIONS: CHILD	
Include relevant features from below. Be sure to address relevant features from each **bolded** category below. **Appearance** Dress, grooming, unusual physical characteristics **Behavior** Activity level, mannerisms, eye contact, manner of relating to parent/therapist, motor behavior, aggression, impulsivity **Socio-Emotional/Mood/Affect** Shy, fearful, labile, sad, blunt, irritable, aggressive, passive, depressed, anxious, risk to self or others State regulation **Cognitive** Attention span and play are age appropriate, problem-solving ability **Communication/Language** Verbal/nonverbal, receptive/expressive, age appropriate **Sensorimotor** Visual, auditory, tactile, vestibular, proprioceptive, taste, textures, smells (avoidant, neutral, seeking) **Gross Motor** Coordination, motor planning, muscle tone (low, floppy, tense), postural stability **Fine Motor** Coordination, tremors, etc. **Adaptive Functioning** Age appropriate self-care, feeding, toileting **Strengths** Adaptive capacity, strengths & assets, cooperation	Provide a description of this child based on your observations.

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

VIII. OBSERVED CAREGIVER – CHILD INTERACTION	
Be sure to address relevant features from each **bolded** category below.	Provide a description based on your observations of child & caregiver interaction.
Behavioral Observations Eye contact Behavioral quality of the interaction Affective tone Psychological involvement (DC 0-3R, Axis II)	
Capacities for Emotional and Social Functioning Attention and regulation Forming relationships/mutual engagement Intentional two-way communication Complex gestures and problem solving Use of symbols to express thoughts/feelings Connecting symbols logically/abstract thinking (DC 0-3R, Axis V)	
Attunement, Balance & Congruence Caregiver sensitive to infant cues and responds accordingly.	

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

IX. BEHAVIORAL OBSERVATIONS & INTERVIEW with CAREGIVER	
Be sure to address relevant features from each **bolded** category below. **Behavioral Observations** Appearance, manner of relating, expressive style, mood/affect **Caregiver's Perceptions and Expectations** Of the child/baby Of his/herself and parenting **Insight/Strengths/Challenges** Adaptive capacity, strengths & assets, cooperation, insight, judgment, motivation for treatment	Provide a description based on your observations of child & caregiver interaction.

X. SUMMARY & FORMULATION

(Brief description of child problems/strengths and primary family and environmental issues that support diagnosis. Be sure to include symptoms/impairments in life functioning i.e. school, home, community, living arrangement, etc.)

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

XI. DIAGNOSTIC CLASSIFICATION

***DC: 0 – 3R* DIAGNOSIS:**

Axis I (Primary Dx):

Axis II : (Relationship Classification)

Relationship quality	No evidence	Some evidence*	Substantial evidence
Overinvolved			
Underinvolved			
Anxious/Tense			
Angry/Hostile			
VerballyAbusive			
PhysicallyAbusive			
SexuallyAbusive			

*Needs further investigation

PIR-GAS w/Caregiver I: _____(Caregiver:_____)
PIR-GAS w/Caregiver 2:_____(Caregiver:_____)
PIR-GAS w/Caregiver 3:_____(Caregiver:_____)

Axis III (Medical & Dev. D/O):

Axis IV (Psychosocial Stressors):
Source:

Effects: _____ Mild_____Moderate _____Severe
Duration: _____ Age of onset:_____
Acute: _____ Enduring: _____

Axis V (Functional Emotional Developmental Level):

1 = age-appropriate under all conditions and full range of affect
2 = age-appropriate but vulnerable to stress and/or constricted range of affect
3 = has capacity but not at age appropriate level
4 = inconsistent/needs support and structure to function at this capacity
5 = barely evidences capacity even with support
6 = has not reached this level
N/A = not applicable

_____ Attention and regulation (0-3 mos)
_____ Forming relationships/mutual engagement (3-6 mos)
_____ Intentional two-way communication (4-10 mos)
_____ Complex gestures and problem solving (10-18 mos)
_____ Use of symbols to express thoughts and feelings (18-30 mos)
_____ Connecting symbols logically and abstract thinking (30-48 mos)

***ICD 10* DIAGNOSIS CODE: (To be entered in the IS/IBHIS)**

Primary: _____

Secondary: _____

Other: _____

Other: _____

Other: _____

Other: _____

Other: _____

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health

XII. DISPOSITION/RECOMMENDATION/PLAN

(Consider collaboration between systems and providers and it's impact on the child and family)

XIII. REFERRALS GIVEN

SERVICE:_____

REFERRED TO: _____

DATE: _____ CONTACT NAME: _____ PHONE NUMBER: _____

SERVICE: _____

REFERRED TO: _____

DATE: _____ CONTACT NAME: _____ PHONE NUMBER: _____

SERVICE: _____

REFERRED TO: _____

DATE: _____ CONTACT NAME: _____ PHONE NUMBER: _____

XIV. SIGNATURES

_____	_____	_____	_____
ASSESSOR'S SIGNATURE	TITLE	DISCIPLINE	DATE
_____	_____	_____	_____
CO-SIGNATURE	TITLE	DISCIPLINE	DATE

Name: **MIS #:**

Agency: **Prov. #:**

Los Angeles County – Department of Mental Health